STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005107	A. BUILDING: _____ B. WING _____	09/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN ST ANTHONY HEALTH - CROWN POINT	1201 S MAIN ST CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This survey was for the investigation of one State complaint. Complaint number: IN00160660 Unsubstantiated; lack of sufficient evidence Date of survey: 9/29/2015 Facility: #005107 Franciscan St. Anthony Health is in compliance with 410 IAC 15-1.6-2, Emergency Services, and 410 IAC 15-1.5-6 Nursing Services, Hospital Licensure Rules.	S 000		